STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155270	A. BUILDING 00 B. WING	03/25/2011

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CORE OF HUNTINGBURG INC	510 WEST MEDCALF DALE, IN47523

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F0000	This visit was for a Recertification and Licensure survey. Survey dates: March 21, 22, 23, 24, 25, 2011 Facility number: 000170 Provider number: 155270 Aim number: 100287490 Survey team: Carole McDaniel RN TC Martha Saull RN Liz Harper RN Census bed type: SNF/NF: 45 Total: 45 Census payor type: Medicare: 1 Medicaid: 40 Other: 4 Total: 45 Sample: 12 These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2. Quality review completed 3-29-11 Cathy Emswiller RN	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F0225 SS=E	Based on record review and interview, the facility failed to thoroughly investigate past work histories of applicants by reference checks prior to hire for 4 of 4 employee files reviewed. RN #2, CNA #1, CNA #2 and Cook #1 Findings include: On 3/23/11 at 10:00 A.M., the staff applications were reviewed for reference checks. All 4 applications indicated 3 prior employment contacts and 3 personal character references for RN #2, CNA #1, CNA #2 and Cook #1. Documentation was lacking to indicate contacts were made to check references and work histories for RN #2, CNA #1, CNA #2 and Cook #1. On 3/24/11 at 9:00 A.M., the pre-orientation form indicated to "-check references (employment history and personal references)." On 3/24/11 at 10:00 A.M. the Administrator was interviewed. She indicated she believed prior employers of the prospective employees would provide only dates employed but documentation of the contacts with the employers was lacking.	F0225	1. It is the policy of this facility to thoroughly investigate past work histories of applicants by reference checks prior to hire.2. All other employee files will be reviewed to ensure they have the appropriate references. The affected staff members Reference Checks have been completed to ensure compliance and they include RN #1, CNA #1 and #2, and Cook #1.3. A new Employee Reference Form has been developed to include both personal and professional checks and is being used prior to offering employment. The Administrator is checking the reference form prior to approving any new hire. A new policy has been written regarding Refence Checks prior to employment.4. The Administrator or Designee is checking all new employee files to ensure reference checks are complete. All other files will be audited and updated with current reference forms if not completed already. The Administrator will audit employee files weekly for six weeks and monthly thereafter to ensure compliance.	04/24/2011

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F0250 SS=E	Based on observation, interview and record review, the facility failed to ensure the resident's behaviors and/or psychosocial needs were monitored and/or assessed and/or evaluated for effectiveness of interventions, if and when attempted to, modify the behaviors for 4 of 4 residents reviewed with a history of elopement attempts and/or 1 of 1 resident (Resident #35) with an observed elopement attempt in a sample of 12. Resident #35, Resident #42, Resident #15, Resident #5 Findings include: The clinical record of Resident #35 was reviewed on 3 /21/11 at 12:50 P.M. Diagnoses included, but were not limited to the following: Dementia, Depression, Chronic Obstructive Pulmonary Disease, Anemia, Seizure Disorder, Diabetic Type II, Aphasia and history of stroke. The most recent MDS (minimum data set assessment) dated 2/27/11 indicated the following for the resident: short tempered/easily annoyed several days; verbal behavioral symptoms exhibited toward others occurred 1 to 3 days; wandered daily; locomotion on and off unit required supervision - oversight, encouragement or cueing; height 64 inches (5 feet, 4 inches) weight 196 pounds.	F0250	It is the policy of this facility to provide medically related social services to attain or maintain the hightest practicable physical, mental and psychosocial well-being of each resident.1] A new digital camera system was purchased to provide Elopement Book pictures in a timely manner.2] Elopement Book pictures and Elopement Assessment, Prevention and Management Care Plan will be initiated within 24 hours of Wanderguard order from Physician.3] Elopement Policy will be re-inserviced to all employees by April 24, 2011.4] The Director of Nursing will conduct daily audits of the Elopement Book/Careplan x 2 weeks, weekly audit x 2 weeks, bi-weekly audits x 4 weeks, then monthly there after.1) Social Services will implement a new policy and procedure for 1:1 supervision of residents and tracking form to be used. Staff to be inserviced on the new policy.2) Nurses on duty will initiate the 1:1 supervision and complete the 1:1 form and assign a staff member to do the 1:1 and track the mood and activity of the resident.3) Social Services will review and monitor the occurences of the 1:1 supervision daily during clinical review.	04/24/2011

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The resident was admitted to the facility on 2/18/11. An admission assessment was dated 2/18/11. The assessment included, but was not limited to, the following: resident is independently mobile, cognitively impaired and is exit seeking.

An assessment of cognitive status, dated 2/22/11 included, but was not limited to, the following: "short term and long term memory impaired; daily decisions moderately impaired."

Nurses notes indicated the following:

On 2/18/11 at 1330 (1:30 P.M.): "Resident arrived to facility ambulatory-...Several attempts to leave unit - wander guard on. Has been getting a little agitated when redirected from attempts to leave unit..."

At 2:30 P.M. "Becoming increased anxious with aggression toward staff...constantly active, wandering into rooms and pulling at locked doors - frequent redirection with agitation when staff attempts to redirect..." Documentation indicated the resident was on 15 minute checks starting at 2:30 P.M. until 2/21/11 at 5:45 A.M.

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	At 3:30 P.M. "Res (resident) continuously attempting to exit bldg (building). Showing s/s (signs/symptoms) physical aggression..." At 5:30 P.M. "Attempted to go out exit door by DR (dining room) few times. Unable to redirect..." At 10:00 P.M.: "...cont (continue) to attempt to open exit doors..." On 2/19/11 at 10:10 A.M.: "Very hard to redirect. Trying to elope from unit. Goes to exit door et (and) pulls on it...tried to redirect...but still tries to elope from both exits..." At 1 P.M.: "Trying to exit unit again...but redirects poorly from exit." At 1:15 P.M.: "Packed clothing et (and) placed in w/c (wheelchair). Attempting to leave the unit. Very resistive et becoming highly agitated..." At 7:30 P.M.: "Resident severely agitated, slapping at nurse as she tries to get out of locked unit. Cont (continue) to pull doors and set off door alarm. Redirect not effective, yelling to "get away."..." A plan of care, dated 2/21/11, indicated			

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the following: "Wandering, potential for elopement or safety risk related to: Lost, restless, environmental stimuli..."

On 2/22/11 at 10:00 A.M.: "...disoriented to time et place. Wandering more today et more difficult to redirect...requires 1:1 attention..."

On 2/24/11 at 8 P.M.: "...Is constantly trying to open unit door..."

On 2/26/11 at 0020 (12:20 A.M.): "...Cont. (continue) to exit seek setting alarm off. Makes inappropriate comments to other residents and staff. Redirection is not effective...Wanderguard on left ankle..."

On 2/27/11 at 10:00 A.M.: "...Has been constantly attempting to seek exit from unit - has been successful et resident on 1:1...agitated with redirection. Very persistently attempting these behaviors et unable to redirect." This entry was documented by RN #1.

On 3/23/11 at 9 A.M. RN #1 was interviewed. She indicated the resident didn't elope from the unit but when she stated "successful" she meant the resident's 1:1 was successful.

On 2/27/11 at 12 P.M.: "Resident

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	increase behaviors with time after time exit seeking 1:1 with nursing staff who is standing between her and doors to prevent her leaving unit - has wanderguard but has **figured our system will release after constant pressure. Very agitated et displayed physical aggression with CNA (certified nursing assistant) and nurses..."** At 5:45 P.M.: "Was able to pull on unit doors enough to get them open. Staff was on the way down hallway, but resident exited before they could reach her. Resident was combative with staff and was cursing. Staff has been redirecting this resident all shift away from doors and out of resident rooms and away from nurses area..." At 8:30 P.M.: "...Is constantly attempting to leave unit. Can be redirected at times but has been mostly uncooperative..." On 3/1/11 at 9 A.M.: "Trying several times to exit unit. Stays at exit door et difficult to redirect..." At 10:30 A.M.: "Resident at exit door. Has a bag of clothes with her and attempting to leave unit several times. Very difficult to redirect..."			

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	On 3/3/11 at 12:40 P.M.: "...continual attempts to elope from unit - from front door to back door - very aggressive with staff; yelling loudly at staff when attempting to redirect - has been unredirectable [sic] - guarding the exits..." On 3/4/11 at 1 P.M.: "Intensely trying to elope between breakfast and 10:30 A.M. Went to both exit doors et tried to elope...." At 9:30 P.M.: "Wandering into rms (rooms) exit seeking attempting to become phy (physically) agg (aggressive)..." On 3/11/11 at 8 P.M.: "Resident has tried most of evening to elope - difficult to redirect at x's (times)..." On 3/15/11 at 7:30 P.M.: "Res exhibiting elopement behaviors." On 3/16/11 at 2:15 P.M. and 4 P.M., "Res. exhibiting elopement behaviors." On 3/17/11 at 9:30 A.M., "Increased aggression since morning. Pulling on unit doors, attempting elopement." On 3/19/11 at 9 A.M.: "...Resident verbally aggressive et trying to elope all			

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shift. Redirects poorly..."

At 2 P.M.: "Res. has been combative with staff...very reluctant to change direction. Has been exit seeking and will wait till alarm sounds solid and then walk out..."

Nurses notes dated 3/20/11 at 12:30 P.M. indicated the following: "Tried to leave unit. More difficult to redirect."

Nurses notes dated 3/20/11 at 1:45 P.M. indicated the following: "Got out of unit, slightly with cursing. Went on a walk with staff outside of unit. Tried to go outdoors. Resistive." This entry was documented by LPN #1.

On 3/23/11 at 11:30 A.M., LPN #1 was interviewed regarding the above entry. She indicated the resident "didn't really get off the unit." She indicated "I was the only one on the unit at the time" and she heard the alarm go off and when she got to the resident the door was opened. She indicated the resident got the door opened by holding constant pressure on it. She indicated she summoned help from the other unit and staff walked the resident outside. LPN #1 indicated the resident was "resistive" to being returned inside the building.

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	On 3/22/11 at 12 P.M., the Elopement Book on the secure unit was observed. This book had a total of 15 resident descriptions in it. Current photographs were lacking for 4 residents, of which included residents #35, #42, #15 and #5. At 12:45 P.M., the DON was interviewed. She indicated the facility camera broke down before she left on vacation (on 3/13/11) and a staff member was going to bring in her own camera to use. She indicated Residents #5 and #15 refused to have their photo taken. Resident #42 had been admitted to the unit on 3/2/11 and Resident #35 had been admitted to the unit on 2/18/11. The DON indicated there was one elopement book in the facility which was housed on the east unit. On 3/22/11 at 1:30 P.M., a current, undated, copy of the policy and procedure for "Elopement Policy and Procedure" was provided by the SSD (social service director). This policy included, but was not limited to, the following: "maintain a current protected list of names and photographs of residents identified to be at risk for elopement..." On 3/22/11 at 1:50 P.M., Resident #35 was observed approaching the interior, unit exit doors. The doors had not been fully closed and light was able to be			

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	observed between the doors (of which one was lipped). The alarm sounded as Resident #35 was walking towards the ajar doors. The door had a window located on the upper portion. Resident #35 opened the door and stood in the doorway. A visitor in the hall from outside the unit, blocked the resident from exiting and engaged the resident in conversation. The resident was standing at the open door, unattended. No staff were observed in the interior unit or exterior unit hallway. At 1:57 P.M., CNA #4 approached the resident from inside the unit. At this time, the PT (Physical Therapy) Director approached the unit from the interior door. He indicated the reason the door was not closed/latched was due to the wind outside and the air flow/pressure in the building. He indicated "a whole lot of air flooding through here when the doors are open on east hall for the residents to go outside for smoke breaks." He indicated the wind creates a vacuum and the door doesn't close all the way. On 3/22/11 at 2:45 P.M., the DON was interviewed. She indicated documentation was lacking of an admission elopement assessment of this resident in the clinical record. She indicated the resident had a wanderguard place on her on admission due to her			

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	history of elopement a at prior facility. At this time, the DON provided an "Elopement plan of care: Assessment, prevention and management" dated 3/22/11. This form included but was not limited to the following: "Risk factors: elopement history, expresses desire to leave, impaired cognition...independently mobile...anxious, psychiatric history, restless, irritable...history of exit seeking behavior." On 3/23/11 at 9 A.M., nurses notes for 3/22/11 were reviewed. They included but were not limited to the following: (The first entry after a 1 P.M. note): At 6 P.M.: "continue to monitor for changes"; at 8 P.M.: "increased behaviors, mult (multiple) attempts at elopement. Aggressive with staff, when redirection attempted..." Documentation was lacking of the above circumstances of the resident with the unit door open on 3/22/11 at 1:50 P.M. On 3/23//11 at 11 A.M., the SSD (Social Service Director) and DON (Director of Nursing) were interviewed. They indicated the above 2 P.M. entry did not indicate the resident was off of the unit. They indicated they were not aware of the resident having gotten off the unit at any time. They indicated the reason the resident was admitted here was because at			

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	the facility she was at prior to this admission, she eloped from the building. On 3/24/11 at 1:30 P.M., the SSD was interviewed. She indicated the facility "really doesn't have a policy and procedure for 1:1 monitoring" and indicated they use the care plan "Behavior Management Careplan." She indicated a resident is placed on 15 minutes checks if they have a physical or verbal behavior and the resident is kept on 15 minute checks for 72 hours. She indicated the resident is put on 1:1 monitoring if the resident is not able to be redirected or acts out at someone else. She indicated this resident has "been on 1:1s a lot." She indicated the facility didn't really have a 1:1 tracking form they just document in the chart "1:1" and continue this until the resident is calm. She indicated if the resident is not calmed down in 2 hours, the physician is called. Interventions on the Behavior Management Care plan, blank copy provided by the SSD on 3/24/11 at 1:30 P.M., included but were not limited to the following: "Allow resident to express feelings: Allow resident to verbally guide you through the ADL (activities of daily living) process; redirect when having inappropriate behavior and allow quiet time; provide 1:1 conversation and allow quiet time; educate regarding coping strategies;			

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	If...other sig (significant) behavior occurs:...ensure safety of resident...contact SSD or DON...log behavior on 72 hour acute charting and nurses notes,..use one of the following until beh (behavior) resolved: 1:1, 15 min checks, med change per MD (medical doctor)..." On 3/25/11 at 11:20 A.M., the DON (Director of Nursing) was interviewed. She indicated after reviewing the resident nurses notes on 2/22/11 at 10 A.M. and 2/27/11 at 10 A.M., she was unable to identify how long the resident was on 1:1s, and unable to track or trend the circumstances and/or attempted interventions of resolution of the behavior of the 1:1 incident. The DON indicated a resident on 1:1 supervision was more intense monitoring than a resident on 15 minute checks and the facility did not have any policy and procedure for 1:1 monitoring of residents and or no form to document and/or to monitor 1:1 supervision. The DON indicated the SSD determines if a resident is to be on 1:1 supervision. She indicated she and the SSD review the documented 15 minute check forms daily for tracking and trending. All of the resident's social service notes were reviewed for the entries of February 2011. Entries were documented for			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORE OF HUNTINGBURG INC	510 WEST MEDCALF DALE, IN47523

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	2/18/11, 2/22/11 and 2/28/11. Documentation was lacking of the resident having been on 1:1 supervision. 3.1-34(a)			

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F0272 SS=D	Based on observation, interview and record review, the facility failed to ensure the resident's behaviors and/or psychosocial needs were monitored and/or assessed and/or evaluated for effectiveness of interventions if and when attempted to modify the behaviors for 1 of 1 residents reviewed with observed elopement attempts in a sample of 12. Resident #35 Findings include: The clinical record of Resident #35 was reviewed on 3 /21/11 at 12:50 P.M. Diagnoses included but were not limited to the following: Dementia, Depression, Chronic Obstructive Pulmonary Disease, Anemia, Seizure Disorder, Diabetic Type II, Aphasia and history of stroke. The most recent MDS (minimum data set assessment) dated 2/27/11 indicated the following for the resident: short tempered/easily annoyed several days; verbal behavioral symptoms exhibited toward others occurred 1 to 3 days; wandered daily; locomotion on and off unit required supervision - oversight, encouragement or cueing; height 64 inches (5 feet, 4 inches) weight 196 pounds. The resident was admitted to the facility on 2/18/11. An admission assessment	F0272	It is the policy of this facility to conduct initially and periodically a comprehensive assessment of each resident's functional capacity.1) Resident #35 was unable to be interviewed for demographic information. Proceeded with the completion of the assessment and notified the resident's children for more accurate information. 2) Social Services reviewed current comprehensive assessment and made revisions to include all the documentation required by the RAI specified by the state.3) All other resident charts to be audited for completion of the assessment and reviewed. 4) Social Service Comprehensive assessment is to be completed at admission and reviewed quarterly.	04/24/2011

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was dated 2/18/11. The assessment included, but was not limited to, the following: resident is independently mobile, cognitively impaired and is exit seeking.

An assessment of cognitive status, dated 2/22/11 included, but was not limited to, the following: "short term and long term memory impaired; daily decisions moderately impaired."

Nurses notes indicated the following:

On 2/18/11 at 1330 (1:30 P.M.): "Resident arrived to facility ambulatory-...Several attempts to leave unit - wander guard on. Has been getting a little agitated when redirected from attempts to leave unit..."

At 2:30 P.M. "Becoming increased anxious with aggression toward staff...constantly active, wandering into rooms and pulling at locked doors - frequent redirection with agitation when staff attempts to redirect..." Documentation indicated the resident was on 15 minute checks starting at 2:30 P.M. until 2/21/11 at 5:45 A.M.

At 3:30 P.M. "Res (resident) continuously attempting to exit bldg (building). Showing s/s (signs/symptoms) physical

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aggression..."

At 5:30 P.M. "Attempted to go out exit door by DR (dining room) few times. Unable to redirect..."

At 10:00 P.M.: "...cont (continue) to attempt to open exit doors..."

On 2/19/11 at 10:10 A.M.: "Very hard to redirect. Trying to elope from unit. Goes to exit door et (and) pulls on it...tried to redirect...but still tries to elope from both exits..."

At 1 P.M.: "Trying to exit unit again...but redirects poorly from exit."

At 1:15 P.M.: "Packed clothing et (and) placed in w/c (wheelchair). Attempting to leave the unit. Very resistive et becoming highly agitated..."

At 7:30 P.M.: "Resident severely agitated, slapping at nurse as she tries to get out of locked unit. Cont (continue) to pull doors and set off door alarm. Redirect not effective, yelling to "get away."..."

A plan of care, dated 2/21/11, indicated the following: "Wandering, potential for elopement or safety risk related to: Lost, restless, environmental stimuli..."

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On 2/22/11 at 10:00 A.M.: "...disoriented to time et place. Wandering more today et more difficult to redirect...requires 1:1 attention..."

On 2/24/11 at 8 P.M.: "...Is constantly trying to open unit door..."

On 2/26/11 at 0020 (12:20 A.M.): "...Cont. (continue) to exit seek setting alarm off. Makes inappropriate comments to other residents and staff. Redirection is not effective...Wanderguard on left ankle..."

On 2/27/11 at 10:00 A.M.: "...Has been constantly attempting to seek exit from unit - has been successful et resident on 1:1...agitated with redirection. Very persistently attempting these behaviors et unable to redirect." This entry was documented by RN #1.

On 3/23/11 at 9 A.M. RN #1 was interviewed. She indicated the resident didn't elope from the unit but when she stated "successful" she meant the resident's 1:1 was successful.

On 2/27/11 at 12 P.M.: "Resident increase behaviors with time after time exit seeking 1:1 with nursing staff who is standing between her and doors to prevent

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	her leaving unit - has wanderguard but has **figured our system will release after constant pressure. Very agitated et displayed physical aggression with CNA (certified nursing assistant) and nurses..."** At 5:45 P.M.: "Was able to pull on unit doors enough to get them open. Staff was on the way down hallway, but resident exited before they could reach her. Resident was combative with staff and was cursing. Staff has been redirecting this resident all shift away from doors and out of resident rooms and away from nurses area..." At 8:30 P.M.: "...Is constantly attempting to leave unit. Can be redirected at times but has been mostly uncooperative..." On 3/1/11 at 9 A.M.: "Trying several times to exit unit. Stays at exit door et difficult to redirect..." At 10:30 A.M.: "Resident at exit door. Has a bag of clothes with her and attempting to leave unit several times. Very difficult to redirect..." On 3/3/11 at 12:40 P.M.: "...continual attempts to elope from unit - from front door to back door - very aggressive with			

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staff; yelling loudly at staff when attempting to redirect - has been unredirectable - guarding the exits..."

On 3/4/11 at 1 P.M.: "Intensely trying to elope between breakfast and 10:30 A.M. Went to both exit doors et tried to elope...."

At 9:30 P.M.: "Wandering into rms (rooms) exit seeking attempting to become phy (physically) agg (aggressive)..."

On 3/11/11 at 8 P.M.: "Resident has tried most of evening to elope - difficult to redirect at x's (times)..."

On 3/15/11 at 7:30 P.M.: "Res exhibiting elopement behaviors."

On 3/16/11 at 2:15 P.M. and 4 P.M., "Res. exhibiting elopement behaviors."

On 3/17/11 at 9:30 A.M., "Increased aggression since morning. Pulling on unit doors, attempting elopement."

On 3/19/11 at 9 A.M.: "...Resident verbally aggressive et trying to elope all shift. Redirects poorly..."

At 2 P.M.: "Res. has been combative with staff...very reluctant to change

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direction. Has been exit seeking and will wait till alarm sounds solid and then walk out..."

Nurses notes dated 3/20/11 at 12:30 P.M. indicated the following: "Tried to leave unit. More difficult to redirect."

Nurses notes dated 3/20/11 at 1:45 P.M. indicated the following: "Got out of unit, slightly with cursing. Went on a walk with staff outside of unit. Tried to go outdoors. Resistive." This entry was documented by LPN #1.

On 3/23/11 at 11:30 A.M., LPN #1 was interviewed regarding the above entry. She indicated the resident "didn't really get off the unit." She indicated "I was the only one on the unit at the time" and she heard the alarm go off and when she got to the resident the door was opened. She indicated the resident got the door opened by holding constant pressure on it. She indicated she summoned help from the other unit and staff walked the resident outside. LPN #1 indicated the resident was "resistive" to being returned inside the building.

On 3/22/11 at 2:45 P.M., the DON was interviewed. She indicated documentation was lacking of an admission elopement assessment of this

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resident in the clinical record. She indicated the resident had a wanderguard place on her on admission due to her history of elopement at prior facility. At this time, the DON provided an "Elopement plan of care: Assessment, prevention and management" dated 3/22/11. This form included but was not limited to the following: "Risk factors: elopement history, expresses desire to leave, impaired cognition...independently mobile...anxious, psychiatric history, restless, irritable...history of exit seeking behavior."

On 3/23/11 at 9 A.M., nurses notes for 3/22/11 were reviewed. They included but were not limited to the following: (The first entry after a 1 P.M. note): At 6 P.M.: "continue to monitor for changes"; at 8 P.M.: "increased behaviors, mult (multiple) attempts at elopement. Aggressive with staff, when redirection attempted..." Documentation was lacking of the above circumstances of the resident with the unit door open on 3/22/11 at 1:50 P.M.

On 3/23//11 at 11 A.M., the SSD (Social Service Director) and DON (Director of Nursing) were interviewed. They indicated the above 2 P.M. entry did not indicate the resident was off of the unit. They indicated they were not aware of the

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resident having gotten off the unit at any time. They indicated the reason the resident was admitted here was because at the facility she was at prior to this admission, she eloped from the building.

On 3/24/11 at 1:30 P.M., the SSD was interviewed. She indicated the facility "really doesn't have a policy and procedure for 1:1 monitoring" and indicated they use the care plan "Behavior Management Careplan." She indicated a resident is placed on 15 minutes checks if they have a physical or verbal behavior and the resident is kept on 15 minute checks for 72 hours. She indicated the resident is put on 1:1 monitoring if the resident is not able to be redirected or acts out at someone else. She indicated this resident has "been on 1:1s a lot." She indicated the facility didn't really have a 1:1 tracking form they just document in the chart "1:1" and continue this until the resident is calm. She indicated if the resident is not calmed down in 2 hours, the physician is called. On the blank Behavior Management Careplan, provided by the SSD on 3/24/11 at 1:30 P.M., interventions included but were not limited to the following: "Allow resident to express feelings: Allow resident to verbally guide you through the ADL (activities of daily living) process; redirect when having inappropriate behavior and

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	allow quiet time; provide 1:1 conversation and allow quiet time; educate regarding coping strategies; If...other sig (significant) behavior occurs:...ensure safety of resident...contact SSD or DON...log behavior on 72 hour acute charting and nurses notes,..use one of the following until beh (behavior) resolved: 1:1, 15 min checks, med change per MD (medical doctor)..." On 3/25/11 at 11:20 A.M., the DON (Director of Nursing) was interviewed. She indicated after reviewing the resident nurses notes on 2/22/11 at 10 A.M. and 2/27/11 at 10 A.M., she was unable to identify how long the resident was on 1:1s, and unable to track or trend the circumstances and/or attempted interventions of resolution of the behavior of the 1:1 incident. The DON indicated a resident on 1:1 supervision was more intense monitoring than a resident on 15 minute checks and the facility did not have any policy and procedure for 1:1 monitoring of residents and or no form to document and/or to monitor 1:1 supervision. The DON indicated the SSD determines if a resident is to be on 1:1 supervision. She indicated she and the SSD review the documented 15 minute check forms daily for tracking and trending.			

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	All of the resident's social service notes were reviewed for the entries of February 2011. Entries were documented for 2/18/11, 2/22/11 and 2/28/11. Documentation was lacking of the resident having been on 1:1 supervision. 3.1-31(e)			

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F0282 SS=D	Based on record review and observation, the facility failed to ensure Certified Nurse Aides did not perform tasks/duties outside their scope of practice and for which they had not been trained for 1 of 4 residents from a sample of 4 observed to receive care by Certified Nurses Aides. (Resident # 12) Findings include: On 3/22/11 at 9:15 A.M., during observation for a bathing activity, it was observed that after Resident # 12 was transferred from the wheelchair to a sitting position inside the whirlpool. Nurses aide # 3, wearing gloves, removed the residents clothing and removed the dressing from the residents right outer ankle. Nurse Aide # 3 placed her gloves and dressing in the trash and left the room without handwashing. The clinical record of Resident #12 was reviewed on 3/23/11 at 9:30 A.M. Diagnosis' included, but were not limited to, recurrent wound of the lower extremity, hepatitis C, insulin dependent diabetes, and right hemiparesis. A physician's order dated 2/5/11 for treatment to the right outer melleous indicated to cleanse with wound cleanser, cover wound with collagen and bactroban,	F0282	It is the policy of this facility to provide services or arrange for services to be provided by qualified persons in accordance with each resident's written plan of care.1] All nursing employees will be inserviced on proper licensed personnel to do all treatments and dressing application/removal by April 24, 2011.2] All employees will be inserviced on proper glove use and handwashing techniques by April 24, 2011. 3] Handwashing/Antimicrobial gel use will be monitored daily x 2 weeks, weekly x 2 weeks, bi-weekly x 4 weeks, monthly x 2 months, then quarterly thereafter.	04/24/2011

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	cover with dry dressing daily. The State of Indiana Nurse Aide training Core curriculum, Copyright, July, 1998 reviewed on 3/25/11 at 10:00 A.M., did not include training for removal of dressing(s) as part of the Nurse Aide Scope of Practice. 3.1-35(g) 3.1-14(i)			

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F0323 SS=E	Based on observation, interview and record review, the facility failed to ensure adequate supervision of a resident with a wanderguard, with known elopement risk, to respond to door alarms in a timely manner and/or have identifying photograph in elopement book and/or ensure door mechanism adequately secured the wanderguarded resident for 1 of 3 residents reviewed on the dementia unit with wanderguards in a sample of 12, with the potential to affect 14 total residents on the dementia unit with wanderguards (a device which is worn by residents which are at risk for elopement to prevent unsupervised exit from the unit). Resident #35, #5, #15, #42 Findings include: During initial tour of the facility on 3/21/11 at 8 A.M., the following was observed: The facility is located on a two lane county road. The facility had an unlocked entry door upon approach to the building, which connected to a lobby followed by another set of unlocked door which entered into the main hall of the building. The main hall of the building extended to the right (west) and left (east), both with patient rooms. The East hall had a set of doors at the entrance which	F0323	1. It is the policy of this facility to ensure the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Staff will respond to all door and personal alarms immediately. Photographs will be placed in Elopement book within 24 hours of Wanderguard order. The Maintenance Supervisor adjusted the door and added one closure to the affected door. Residents # 35, #5, #15 and #42 now have photos in the elopement book.2. Upon admission or an elopement order photographs will be taken and placed in the book within 24 hours.3. Staff will be inserviced to respond to ALL alarms immediately. The elopement policy now states photographs will be taken within 24 hours upon receipt of wanderguard order and placed in elopement book. And the door will be monitored daily by the Maintenance Supervisor for one month and then biweekly for one month and monthly after.4. All staff will monitor alarms by responding immediately to alarms. The Director of Nursing will monitor the elopement book weekly x 2 weeks, biweekly x 4 weeks and monthly thereafter. The Maintenance Director will monitor the door weekly for one month and then biweekly for one month and monthly thereafter.	04/24/2011

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	lock and alarm when approached by a resident with a wanderguard. One of the doors has a lipped edge to it. Upon entry to the unit, the unit was an upside down "L" shape, with an exit door at each end. The far exit door is also alarmed for wanderguards and exits to the outside, unsecured courtyard on the back side of the building. The clinical record of Resident #35 was reviewed on 3 /21/11 at 12:50 P.M. Diagnoses included but were not limited to the following: Dementia, Depression, Chronic Obstructive Pulmonary Disease, Anemia, Seizure Disorder, Diabetic Type II, Aphasia and history of stroke. The most recent MDS (minimum data set assessment) dated 2/27/11 indicated the following for the resident: short tempered/easily annoyed several days; verbal behavioral symptoms exhibited toward others occurred 1 to 3 days; wandered daily; locomotion on and off unit required supervision - oversight, encouragement or cueing; height 64 inches (5 feet, 4 inches) weight 196 pounds. The resident was admitted to the facility on 2/18/11. An admission assessment was dated 2/18/11. The assessment included, but was not limited to, the following: resident is independently			

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mobile, cognitively impaired and is exit seeking.

An assessment of cognitive status, dated 2/22/11 included, but was not limited to, the following: "short term and long term memory impaired; daily decisions moderately impaired."

Nurses notes indicated the following:

On 2/18/11 at 1330 (1:30 P.M.): "Resident arrived to facility ambulatory-...Several attempts to leave unit - wander guard on. Has been getting a little agitated when redirected from attempts to leave unit..."

At 2:30 P.M. "Becoming increased anxious with aggression toward staff...constantly active, wandering into rooms and pulling at locked doors - frequent redirection with agitation when staff attempts to redirect..." Documentation indicated resident was on 15 minute checks starting at 2:30 P.M. until 2/21/11 at 5:45 A.M.

At 3:30 P.M. "Res (resident) continuously attempting to exit bldg (building). Showing s/s (signs/symptoms) physical aggression..."

At 5:30 P.M. "Attempted to go out exit

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	door by DR (dining room) few times. Unable to redirect..." At 10:00 P.M.: "...cont (continue) to attempt to open exit doors..." On 2/19/11 at 10:10 A.M.: "Very hard to redirect. Trying to elope from unit. Goes to exit door et (and) pulls on it...tried to redirect...but still tries to elope from both exits..." At 1 P.M.: "Trying to exit unit again...but redirects poorly from exit." At 1:15 P.M.: "Packed clothing et (and) placed in w/c (wheelchair). Attempting to leave the unit. Very resistive et becoming highly agitated..." At 7:30 P.M.: "Resident severely agitated, slapping at nurse as she tries to get out of locked unit. Cont (continue) to pull doors and set off door alarm. Redirect not effective, yelling to "get away."..." A plan of care, dated 2/21/11, indicated the following: "Wandering, potential for elopement or safety risk related to: Lost, restless, environmental stimuli..." On 2/21/11 at 6:40 P.M.: "...exit seeking multiple x's (times)..."			

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On 2/22/11 at 10:00 A.M.: "...disoriented to time et place. Wandering more today et more difficult to redirect...requires 1:1 attention..."

On 2/24/11 at 8 P.M.: "...Is constantly trying to open unit door..."

On 2/26/11 at 0020 (12:20 A.M.): "...Cont. (continue) to exit seek setting alarm off. Makes inappropriate comments to other residents and staff. Redirection is not effective...Wanderguard on left ankle..."

On 2/27/11 at 10:00 A.M.: "...Has been constantly attempting to seek exit from unit - has been successful et resident on 1:1...agitated with redirection. Very persistently attempting these behaviors et unable to redirect." This entry was documented by RN #1.

On 3/23/11 at 9 A.M. RN #1 was interviewed. She indicated the resident didn't elope from the unit but when she stated "successful" she meant the resident's 1:1 was successful.

On 2/27/11 at 12 P.M.: "Resident increase behaviors with time after time exit seeking 1:1 with nursing staff who is standing between her and doors to prevent

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	her leaving unit - has wanderguard but has **figured our system will release after constant pressure. Very agitated et displayed physical aggression with CNA (certified nursing assistant) and nurses..."** At 5:45 P.M.: "Was able to pull on unit doors enough to get them open. Staff was on the way down hallway, but resident exited before they could reach her. Resident was combative with staff and was cursing. Staff has been redirecting this resident all shift away from doors and out of resident rooms and away from nurses area..." At 8:30 P.M.: "...Is constantly attempting to leave unit. Can be redirected at times but has been mostly uncooperative..." On 3/1/11 at 9 A.M.: "Trying several times to exit unit. Stays at exit door et difficult to redirect..." At 10:30 A.M.: "Resident at exit door. Has a bag of clothes with her and attempting to leave unit several times. Very difficult to redirect..." At 11:15 A.M. "...cursing at staff. Still trying to elope..."			

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	On 3/3/11 at 12:40 P.M.: "...continual attempts to elope from unit - from front door to back door - very aggressive with staff; yelling loudly at staff when attempting to redirect - has been unredirectable - guarding the exits..." On 3/4/11 at 1 P.M.: "Intensely trying to elope between breakfast and 10:30 A.M. Went to both exit doors et tried to elope...." At 9:30 P.M.: "Wandering into rms (rooms) exit seeking attempting to become phy (physically) agg (aggressive)..." On 3/11/11 at 8 P.M.: "Resident has tried most of evening to elope - difficult to redirect at x's (times)..." On 3/15/11 at 7:30 P.M.: "Res exhibiting elopement behaviors." On 3/16/11 at 2:15 P.M. and 4 P.M., "Res. exhibiting elopement behaviors." On 3/17/11 at 9:30 A.M., "Increased aggression since morning. Pulling on unit doors, attempting elopement." On 3/19/11 at 9 A.M.: "...Resident verbally aggressive et trying to elope all shift. Redirects poorly..."			

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At 2 P.M.: "Res. has been combative with staff...very reluctant to change direction. Has been exit seeking and will wait till alarm sounds solid and then walk out..."

Nurses notes dated 3/20/11 at 12:30 P.M. indicated the following: "Tried to leave unit. More difficult to redirect."

Nurses notes dated 3/20/11 at 1:45 P.M. indicated the following: "Got out of unit, slightly with cursing. Went on a walk with staff outside of unit. Tried to go outdoors. Resistive." This entry was documented by LPN #1.

On 3/23/11 at 11:30 A.M., LPN #1 was interviewed regarding the above entry. She indicated the resident "didn't really get off the unit." She indicated "I was the only one on the unit at the time" and she heard the alarm go off and when she got to the resident the door was opened. She indicated the resident got the door opened by holding constant pressure on it. She indicated she summoned help from the other unit and staff walked the resident outside. LPN #1 indicated the resident was "resistive" to being returned inside the building.

Nurses notes dated 3/20/11 at 3 P.M.

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indicated the following: "Haldol...given after another attempt to leave unit..."

On 3/21/11 at 1:30 P.M., Facility Staff #1 was observed to escort wanderguarded residents off the east unit for a smoke break, (from the door adjacent to the interior of the building). As residents approach the door, the alarm sounded. Residents were observed to be escorted back a distance from the door and the alarm ceased sounding. Staff #1 was observed to enter a code to a key pad located on the wall beside the exit door. Staff #1 then opened the door and escorted the residents out of the unit. As the residents were exiting the unit, the alarm began to sound again. The door closed and the alarm stopped sounding.

At 1:35 P.M., Resident # 35 was observed at the interior exit door of the unit. The resident exhibited no visual characteristics to distinguish her as an cognitively impaired resident. She was observed to be knocking on the door, crying. CNA #3 approached the resident and escorted her off the unit.

On 3/22/11 at 11:30 A.M., RN #2 was observed taking a photograph of Resident #35.

On 3/22/11 at 12 P.M., the Elopement

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	Book on the secure unit was observed. This book had a total of 15 resident descriptions in it. Current photographs were lacking for 4 residents, of which included residents #35, #42, #15 and #5. At 12:45 P.M., the DON was interviewed. She indicated the facility camera broke down before she left on vacation (on 3/13/11) and a staff member was going to bring in her own camera to use. She indicated Residents #5 and #15 refused to have their photo taken. Resident #42 had been admitted to the unit on 3/2/11 and Resident #35 had been admitted to the unit on 2/18/11. The DON indicated there was one elopement book in the facility which was housed on the east unit. On 3/22/11 at 1:30 P.M., a current, undated, copy of the policy and procedure for "Elopement Policy and Procedure" was provided by the SSD (social service director). This policy included, but was not limited to, the following: "maintain a current protected list of names and photographs of residents identified to be at risk for elopement..." On 3/22/11 at 2 P.M., the Maintenance man was observed working on the alarmed entrance door to the East unit. He indicated it is very windy outside today and when that happens, it creates a			

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	vacuum in the building when both smoke doors are open and sometimes the east unit doors don't close all the way. He indicated he was adjusting the tension on the east unit doors to address the above situation. On 3/22/11 at 1:50 P.M., Resident #35 was observed approaching the interior, unit exit doors. The doors had not been fully closed and light was able to be observed between the doors (of which one was lipped). The alarm sounded as Resident #35 was walking towards the ajar doors. The door had a window located on the upper portion. Resident #35 opened the door and stood in the doorway. While a facility visitor blocked the exit from the unit, the resident was prevented from exiting the unit and was engaged in conversation. The resident was standing at the open door, unattended. No staff were observed in the interior unit or exterior unit hallway. At 1:57 P.M., CNA #4 approached the resident from inside the unit. At this time, PT Director approached the unit from the interior door. He indicated the reason the door was not closed/latched was due to the wind outside and the air flow/pressure in the building. He indicated "a whole lot of air flooding through here when the doors are open on east hall for the residents to go outside for smoke breaks."			

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	He indicated the wind creates a vacuum and the door doesn't close all the way. On 3/22/11 at 2:30 P.M., RN #1, who is currently working on the east unit, was interviewed. She indicated at the following times, resident's from the east unit are escorted by staff off the unit and to an outside area to smoke. She indicated resident's who are escorted off the unit for supervised smoking, do have a wanderguard in place. She indicated the supervised smoke times are as follows: 8:30 A.M., 10:30 A.M., 1:30 P.M., 3:30 P.M., 6:30 P.M., and 8:30 P.M. On 3/22/11 at 2:45 P.M., the DON was interviewed. She indicated documentation was lacking of an admission elopement assessment of this resident in the clinical record. She indicated the resident had a wanderguard place on her on admission due to her history of elopement at prior facility. At this time, the DON provided an "Elopement plan of care: Assessment, prevention and management" dated 3/22/11. This form included but was not limited to the following: "Risk factors: elopement history, expresses desire to leave, impaired cognition...independently mobile...anxious, psychiatric history, restless, irritable...history of exit seeking behavior."			

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On 3/23/11 at 9 A.M., nurses notes for 3/22/11 were reviewed. They included but were not limited to the following: (The first entry after a 1 P.M. note): At 6 P.M.: "continue to monitor for changes"; at 8 P.M.: "increased behaviors, mult (multiple) attempts at elopement. Aggressive with staff, when redirection attempted..." Documentation was lacking of the above circumstances of the resident with the unit door open on 3/22/11 at 1:50 P.M.

On 3/23/11 at 10:45 A.M., LPN #1 provided a current copy of the CNA (certified nursing assistant) assignment sheet. This form indicated of the current 17 residents on the unit, 14 had wanderguards on. Of the 4 residents without current photographs, all 4 residents had wanderguards in place, 2 of which had not refused to have photos taken. (Resident #35, #5, #15, #42).

On 3/23//11 at 11 A.M., the SSD (Social Service Director) and DON (Director of Nursing) were interviewed. They indicated the above 2 P.M. entry did not indicate the resident was off of the unit. They indicated they were not aware of the resident having gotten off the unit at any time. They indicated the reason the resident was admitted here was because at

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the facility she was at prior to this admission, she eloped from the building.

On 3/23/11 at 11:15 A.M., RN #2 was interviewed. She indicated the reason the doors to the east unit (which are alarmed when approached by a resident with a wanderguard) are alarmed is"so staff knows she is there."

On 3/24/11 at 1:30 P.M., the SSD was interviewed. She indicated the facility "really doesn't have a policy and procedure for 1:1 monitoring" and indicated they use the care plan "Behavior Management Careplan." She indicated a resident is placed on 15 minutes checks if they have a physical or verbal behavior and the resident is kept on 15 minute checks for 72 hours. She indicated the resident is put on 1:1 monitoring if the resident is not able to be redirected or acts out at someone else. She indicated this resident has "been on 1:1s a lot." She indicated the facility didn't really have a 1:1 tracking form they just document in the chart "1:1" and continue this until the resident is calm. If the resident is not calmed down in 2 hours, the physician is called. Interventions included but were not limited to the following: "Allow resident to express feelings: Allow resident to verbally guide you through the ADL (activities of daily living) process;

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redirect when having inappropriate behavior and allow quiet time; provide 1:1 conversation and allow quiet time; educate regarding coping strategies; If...other sig (significant) behavior occurs:...ensure safety of resident...contact SSD or DON...log behavior on 72 hour acute charting and nurses notes,..use one of the following until beh (behavior) resolved: 1:1, 15 min checks, med change per MD (medical doctor)..."

On 3/24/11 at 2 P.M., the DON was interviewed. She indicated staff get so used to hearing the exit door alarms on the unit.

On 3/25/11 at 6:30 A.M., CNA #3 (who was working on the east unit) was interviewed. She indicated when wanderguarded residents get close to the unit exit door, it alarms. She estimated the distance from a wanderguarded resident to the unit exit door to trigger the alarm, as being about 17 feet. She indicated for wanderguarded residents to be able to go through the alarmed exit doors the following would happen: If they are far enough away from the door, the door can be opened and the wanderguarded resident can exit but the alarm will sound; if the code is entered on the key pad, the alarm will not sound for 10 seconds and the resident can exit. She

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	indicated if the button is pushed on the wall located just outside the unit, the alarm will not sound but "it (the button) is really touchy, if you move the least little bit it will alarm." She indicated when residents go off the unit for smoke breaks, the alarm usually sounds as it takes the number of residents smoking long enough to get through the door, that the alarm sounds. On 3/25/11 at 7 A.M., the Administrator was interviewed. She indicated only staff know the code to enter in on the keypad. Regarding the button on the outside of the unit, as soon as you let off the button, the alarm will sound if a wanderguarded resident is near. The Administrator indicated the only way to silence the alarm when a wanderguarded resident is within range (17 feet on the inside) is to hold the button on the outside or move the resident out of range of the door. On 3/25/11 at 10:15 A.M., the maintenance man was interviewed. He indicated "it needed to be real windy and have both sets of doors open to the outside" to be a problem with the wanderguarded doors not closing properly. 3.1-45(a)(2)			

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F0431 SS=E	Based on observation, record review and interview, the facility failed to ensure safe refrigeration temperature ranges for drug/ biological storage on 2 of 2 units involving 13 of 13 residents using that storage, with the potential to effect 45 residents. Resident #46 Resident #22 Resident #36 Resident #43 Resident #3 Resident #29 Resident# 25 Resident #42 Resident #35 Resident #45 Resident #6 Resident # 15 Resident #4 Findings include: On the West unit on 3/25/11 at 10:15 A.M. the medication room refrigerator temperature was 20 F(Fahrenheit degrees). The drug and biological contents were checked against manufacturer applied labels and/ or pharmacy applied storage direction labels. The refrigerator contents included: a bag of intravenous sodium chloride solution for Resident #46 labeled DO NOT FREEZE which was frozen solid, one dose pack of Resperdol 37.5 mg labeled to store in temperature range of 36-46 F for Resident #22, nine unopened 1 cc(cubic centimeter) vials of Lorazepam 2 mg per cc and one unopened 30 cc bottle of Lorazepam all labeled DO NOT FREEZE for Resident #36, five unopened 1 cc vials of Lorazepam 2 mg per cc for Resident # 43, four unopened 1 cc vials of	F0431	It is the policy of this facility to store all drugs and biologicals in locked compartments under proper temperature control.1] All improperly stored medications were re-ordered March 5, 2011 and the improperly stored medications were destroyed per policy.2] A Medication refrigerator was purchased and placed on East Wing medication room. West Wing medication refrigerator was also replaced with a newer model.3] The facility will continue to monitor refrigerator temperatures nightly with the "Refrigerator and Crash Cart" form.4] All medication refrigerators were numbered for reference purposes.5] New thermometers were placed in the two medication refrigerators.6] All Licensed Staff will be inserviced, as of April 24, 2011, concerning the importance of maintaining medication refrigerator temperature control and reporting any discrepencies immediately.7] A medication refrigerator audit will be done daily x 2 weeks, weekly x 2 weeks, biweekly x 4 weeks, then monthly thereafter, per present policy.	04/24/2011

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	155270	A. BUILDING 00 B. WING	03/25/2011

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	Lorazepam 2 mg per cc for Resident #3 labeled DO NOT FREEZE, one unopened 1 cc vial of Lorazepam 2 mg per cc for Resident #29 and 2 unopened 1 cc vials of Lorazepam 2 mg per cc for Resident # 25. In addition to resident's individual drugs the refrigerator also contained a general stock supply in a locked Emergency Drug Kit (EDK) labeled DO NOT FREEZE. It contained one unopened 5 cc vial of Ativan 2 mg/cc, one unopened multi dose vial of Insulin Novolin R and one unopened dose of Novolog Insulin. There was also a facility supply of Pneumovax vaccine, one multidose unopened via, labeled to store 36 F to 46 F and DO NOT FREEZE. The monitoring log of the West unit medication refrigerator temperatures was posted on the refrigerator door. Daily temperatures had been recorded by the night shift. In the first 25 days of March, recorded temperatures fell to freezing 13 of 25 days. In that time frame the freezing temperatures ranged from 18 F to 32 F. for as long as 4 days in a row. On the East unit on 3/25/11 at 11:00 A.M. the refrigerator temperature was between 32 F and 33 F. The monthly March temperature monitoring log indicated			

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	freezing temperatures on 17 of 24 recorded days with the longest duration of freezing temperature storage being 7 days. The contents of that refrigerator was as follows: one 50 mg dose pack of Resperdol and four unopened 1 cc vials of Lorazepam labeled DO NOT FREEZE for Resident #42, five unopened 1 cc vials of Lorazepam 2 mg/cc for Resident #35 labeled DO NOT FREEZE, five unopened 1 cc vials of Lorazepam 2 mg/cc for Resident #45 Labeled DO NOT FREEZE, four unopened 1 cc vials of Lorazepam 2 mg/cc labeled DO NOT FREEZE for Resident #6 and the same for Resident #15, and for Resident #4 there were 5 unopened 1 cc vials of Lorazepam labeled DO NOT FREEZE stored in the refrigerator. On interview with the Director of Nursing on 3/25/11 at 11:30 A.M., she indicated the West unit refrigerator had just been replaced and she was monitoring logs of each refrigerator at the completion of each month. 3.1-25(m)			

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F0441 SS=E	Based on record review and interview of physicals / mantouxs (tuberculosis skin test) the facility failed to screen employees with the two step method for tuberculosis exposure detection or symptoms of other potential contagious diseases in a sample of 4 of 4 employee records with a potential to affect 45 residents. RN #2, CNA #1, CNA #2 and Cook #1 Findings include: On 3/23/11 at 9:00 A.M., the employee records were reviewed to ensure physicals / mantouxs were administered prior to their start of employment as defined in the pre-orientation checklist. Documentation was lacking for RN #2, CNA #1, CNA #2 and Cook #1. RN #2's employee record was lacking an initial second step mantoux. The physical was signed and dated 3/23/11 after the start date of 1/7/11. CNA #1's employee record was lacking an initial second step mantoux. The physical was signed and dated 3/23/11 after the start date of 2/16/11. CNA #2's employee record was lacking an initial second step mantoux. The physical	F0441	1. It is the policy of this facility to screen all employees with the two step method for tuberculosis exposure detection or symptoms of other potential contagious diseases. The facility will give a PPD prior to hire and the second step will follow one to three weeks after initial PPD.2. Affected Employees include CNA #1 and 2, Cook #1 and RN #1. All employees have had chest XRays to rule out active TB. 3. A new PPD policy has been implemented to ensure 2nd step PPDS are given to all new employees. A file has been placed at the West Wing Nurses station to ensure the employee may be given the 2nd step in the allotted time frame by a qualified nurse. Once the 2nd step is complete the completed ppd form will be forwarded to the Administrator. 4. The Administrator will ensure compliance by monitoring PPD forms weekly for six weeks and then monthly.	04/24/2011

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	was signed and dated for 3/23/11 after the start date of 1/28/11. Cook #1's employee record was lacking an initial second step mantoux. The physical was lacking from the employee file. An interview with the Administrator, 3/23/11 at 12:45 P.M. indicated, "Cook #1 did not show up when the Medical Director was in the facility to do the physicals." An interview with the Inservice Director, 3/23/11 at 10:50 A.M., indicated the second step mantouxs were not completed in the mantoux record. 3.1-18(a) 3.1-18(b)(6) 3.1-18(h)			

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